

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Packer

10693

10692

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 745 Guilford Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 745 Guilford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES COCHRAN		First	Middle	Last	4. DATE OF DEATH Oct 13 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 19 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Reichards Garage		11. BIRTHPLACE (State or foreign country) Emmitsburg Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Stewart Annan		14. MOTHER'S MAIDEN NAME Elizabeth Morrison		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 214-09-1954		17. INFORMANT Mrs Alice Newcomer Annan Hagerstown				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days		
IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Generalised Arteriosclerosis				
IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)		Hypertension C. V. Disease				
IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)		Coronary Thrombosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State) Hagerstown Md (Md)
21. I certify that I attended the deceased from Sept 13, 1955, to Oct 13, 1956, that I last saw the deceased alive on Oct 13, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 10/15/56
ACTUAL SIGNATURE Robert V. L. Campbell								
PHYSICIAN'S NAME (Type) Robert V. L. Campbell								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 15-56		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash Co		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew F. Coffran Hagerstown		ADDRESS		24a. REC'D BY REGISTRAR Oct 17, 1956		24b. REGISTRAR'S SIGNATURE Robert B. Coopers		

DEPARTMENT OF DEFENSE

DEPARTMENT OF DEFENSE

RECEIVED

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10694

10693

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Route # 4	
3. NAME OF DECEASED (Type or print) NANCY		First MIDDLE JEAN	4. DATE OF DEATH Oct. 16 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
13. FATHER'S NAME Kenneth L. Black		14. MOTHER'S MAIDEN NAME Sherley Ann Statler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT Kenneth L. Black R#4 Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0		INTERVAL BETWEEN ONSET AND DEATH 72 hours Pneumonia bilateral	
Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) DUE TO Gastro E. Enteritis		76 hours	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 Oct., 1956, to 16 Oct., 1956, that I last saw the deceased alive on 16 Oct., 1956, and that death occurred at 10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE ELDON G. HOACHLANDER M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 10/16/56	
PHYSICIAN'S NAME (Type) ELDON G. HOACHLANDER M.D.		115 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 18, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 17, 1956	
		24b. REGISTRAR'S SIGNATURE John Powers	

CLASSIFICATION OF DATA

BUREAU V.

OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to a burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10694

CERTIFICATE OF DEATH

10695

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia		b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Near Marlowe		8543			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS On US route 11		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle Frederick	Last Bryan	4. DATE OF DEATH	Month October	Day 27	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1912	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR 4	IF UNDER 24 HRS. Months 4	Days 16	Hours 8	Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Hag. Rubber Co.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin Bryan				14. MOTHER'S MAIDEN NAME Josephine Fisher					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-01-9903		17. INFORMANT Mrs. Katherine Bryan Marlowe, West Vir.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Hypertensive cardio-vascular renal disease 4 years? Rupture of aneurysm of Circle of Willis 2 hours									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm of the thoracic aorta									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 19 , 1953 to Oct 21 , 1956, that I last saw the deceased alive on Oct. 27 , 1956, and that death occurred at 1:02 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 10/27/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf Williamsport, Md.</i>		ADDRESS <i>100 W. Main Street, Williamsport, Md.</i>		24a. REC'D BY REGISTRAR Oct. 30, 1956		24b. REGISTRAR'S SIGNATURE <i>Charles H. Coopers</i>			

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U. S. BUREAU

OCT 31 1956

REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10696

CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		--		414 Brunswick		10-352			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Mary		Maudie	Caniford		10	19	56		
5. SEX		6. COLOR OR RACE	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years (last birthday) yrs.)		10. IF UNDER 1 YEAR Months Days Hours Min.	
Female		White		10-21-1900		55			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles H. Gill Sr.			14. MOTHER'S MAIDEN NAME Catherine Lee						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Jack F. Caniford		Address Brunswick, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 yrs				
381X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO			Cerebral Haemorrhage		6 month				
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.			Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Aug 10</u> , 1956, to <u>Oct 19</u> , 1956, that I last saw the deceased alive on <u>October 17</u> , 1956, and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonesboro								DATE SIGNED Oct 20, 1956	
ACTUAL SIGNATURE G. W. Lee, M.D.									
PHYSICIAN'S NAME (Type) G. W. Lee, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-56		22c. NAME OF CEMETERY OR CREMATORIUM St. Marks		22d. LOCATION (City, town, or county) Petersville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee, Feste			ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE Oct 30 1956		24b. REGISTRAR'S SIGNATURE John H. Beck		

BUREAU V. S.

OCT 30 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10695

CERTIFICATE OF DEATH

10697

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <i>Washington</i> <i>Hagerstown</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b 2 mins.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BABY	Middle GIRL	Last CASTLE		
4. DATE OF DEATH	Month October	Day 22	Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 22, 1956		
9. AGE (In years' last birthday) yrs. 2	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
13. FATHER'S NAME <i>Edward L. Castle</i>	14. MOTHER'S MAIDEN NAME <i>Frances J. Mills</i>		15. ADDRESS <i>Hagerstown, Md.</i>		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	17. SOCIAL SECURITY NO. none	18. INFORMANT Edward L. Castle	19. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>759.3</i> DUE TO <i>Congenital deformities incompatible with life.</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <i>Oct 21</i> , 1956, to <i>Oct 21</i> , 1956, that I last saw the deceased alive on <i>Oct 21</i> , 1956, and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>214 N. Potomac St. Hagerstown, Md.</i> DATE SIGNED <i>10/22/56</i>					
ACTUAL SIGNATURE <i>F. D. Dove Jr.</i>	22. PHYSICIAN'S NAME (Type) <i>F. D. Dove, Jr.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/23/1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven</i>	22d. LOCATION (City, town, or county) (State) <i>Hagerstown, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Suter-Rouzer Funeral Home</i>	ADDRESS <i>Hagerstown, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>Oct 24, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. H. Powers</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 26, 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698
305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Woodsboro</i>		c. LENGTH OF STAY IN 1b <i>8 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Healy-Falvey nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>EDITH LENORA CLEM</i>		First	Middle	Last	4. DATE OF DEATH <i>Oct.</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 22</i>	9. AGE (In years last birthday) <i>70 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. IF UNDER 24 HRS Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Jacob Dudson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bostian</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If not, unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219-30-3786</i>		17. INFORMANT <i>Mrs. Ross Clem, 613 Biggs Ave, Fred.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.2</i>		DUE TO <i>acute angina</i>		DUE TO <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		DUE TO <i>Paralysis agitans</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woodsboro</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Oct 1</i> , 1956, to <i>Oct 14</i> , 1956, that I last saw the deceased alive on <i>October 4, 1956</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. W. Lilean</i>						ADDRESS (Street, city or town, state) <i>Woodsboro</i>		
PHYSICIAN'S NAME (Type) <i>G. Wileman M.D.</i>						DATE SIGNED <i>10/14/56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/17/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Hope</i>		22d. LOCATION (City, town, or county) <i>Woodsboro</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton, Walkersville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>17 Oct. 1956</i>		24b. REGISTRAR'S SIGNATURE <i>John F. Bass</i>		

BUREAU Y. S.

OCT 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10699

10748

CERTIFICATE OF DEATH De Kohler

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		d. STREET ADDRESS Cavetown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cavetown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mae		First Mae	Middle M	Last OLIVE	4. DATE OF DEATH Oct 10 1956	Month Oct	Day 10	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10 1904		9. AGE (In years from birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Canning		11. BIRTHPLACE (State or foreign country) Haville Free School		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John C. Cline			14. MOTHER'S MAIDEN NAME John C. Cline					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Cline		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Generalized Arterio Sclerosis		15 min.		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Arterio Sclerosis Heart		20 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 2</u> , 1956, to <u>Oct 10</u> , 1956, that I last saw the deceased alive on <u>Oct 10</u> , 1956, and that death occurred at <u>14</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE M.D. <u>M. A. Kohler</u> PHYSICIAN'S NAME (Type) <u>M. A. Kohler</u>		ADDRESS (Street, city or town, state) <u>Smithsburg, Md 1956</u> DATE SIGNED <u>10/11/56</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct 10 1956		22c. NAME OF CEMETERY OR CREMATORIAL Cave Hill Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md		
23. FUNERAL DIRECTOR'S SIGNATURE M. A. Kohler		ADDRESS Smithsburg, Md						
		24a. REC'D. BY REGISTRAR DATE <u>Oct 10 1956</u>						
		24b. REGISTRAR'S SIGNATURE						

BUREAU V.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10696

CERTIFICATE OF DEATH

Reg. Dist. No.

10700
302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 7 S. Artizan Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Oliver	Middle Thomas	Last Coakley	4. DATE OF DEATH 10	Month 11	Day 11	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1876	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 11	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer & Fireman		10b. KIND OF BUSINESS OR INDUSTRY Byron Tannery		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip P. Coakley				14. MOTHER'S MAIDEN NAME Ellen C. Carrier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-09-7319		17. INFORMANT Miss Helen Coakley		Address <u>Williamsport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				<u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Oct</u> , 1956, to <u>11 Oct</u> , 1956, that I last saw the deceased alive on <u>10 Oct</u> , 1956, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Paul Haak</u> PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/56		22c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard & Sons Funeral</u>		ADDRESS <u>1616 16th Street, Williamsport, Md.</u>		24a. REC'D BY REGISTRAR Oct 16, 1956		24b. REGISTRAR'S SIGNATURE <u>Howard & Sons Funeral</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

RECEIVED

OCT 18 1956

BUREAU Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10697 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD. Wells 10701
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 27 So Locust St.		e. STREET ADDRESS 27 So Locust St.	
3. NAME OF DECEASED (Type or print) ALBERT ROSS COLLIFLOWER		First	Middle
4. DATE OF DEATH Oct 23 1956		Last	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 1 1890
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Everlys Inc.	
11. BIRTHPLACE (State or foreign country) Graceham Fred Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer E. Colliflower		14. MOTHER'S MAIDEN NAME Elizabeth Willhide	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-3996	
17. INFORMANT Mrs Esther L. Colliflower		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		27 So Locust St Hagerstown MD. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED 10-24-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/56	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rust Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Oct 26 1956	
		24b. REGISTRAR'S SIGNATURE <i>Joseph Bowes</i>	

RECEIVED
BUREAU V.

OCT 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

CERTIFICATE OF DEATH

10702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN lb 63 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg	
3. NAME OF DECEASED (Type or print) Francis Richard Crowther		d. STREET ADDRESS RFD #2	
4. DATE OF DEATH Oct. 31 1956	Month Year	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1876
			9. AGE (in years from birthday) 79
		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) orchardist		10b. KIND OF BUSINESS OR INDUSTRY peach orchard	
10c. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David W. Crowther		14. MOTHER'S MAIDEN NAME Catherine H. Brundage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) G. Rodney Crowther, Leitersburg, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		DUE TO Coronary Thrombosis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Diabetes mellitus		DUE TO 42 yrs	
		DUE TO arterio sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 31 1956 to Oct 31 1956 that I last saw the deceased alive on Oct 31 1956 , and that death occurred at 9:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 10/31/56			
ACTUAL SIGNATURE F. G. Kohler		M.D.	
PHYSICIAN'S NAME (Type) F. G. Kohler			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-3-56	
22c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery		22d. LOCATION (City, town, or county) Smithsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE 10/31/56	
		24b. REGISTRAR'S SIGNATURE W. H. Minnich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G205 10-22-56 et
10698 CERTIFICATE OF DEATH

10703

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 13 Blyden Alley Washington County, Md.								
3. NAME OF DECEASED (Type or print) Alta Scott Davis			4. DATE OF DEATH Oct 3 Day 1956								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-76		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Unknown			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO.			17. INFORMANT Wash. County			Address Home Hag. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u>									INTERVAL BETWEEN ONSET AND DEATH unknown		
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Carcinoma of the lung</u>									unknown		
DUE TO											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart disease</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <u>July 16, 1956</u> , to <u>October 3, 1956</u> , that I last saw the deceased alive on <u>October 3, 1956</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.									ADDRESS (Street, city or town, state) Clear Spring, Maryland		DATE SIGNED October 4, 1956
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Oct 4 - 56</u>			22c. NAME OF CEMETERY OR CREMATORIAL <u>Arch. Robert Cohen</u>			22d. LOCATION (City, town, or county) <u>Baltimore Md.</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son			ADDRESS Hagerstown Md.			24a. REC'D BY REGISTRAR DATE <u>Oct 4 1956</u>			24b. REGISTRAR'S SIGNATURE		

BUREAU V. S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10699 **Dr Earl Young** 10704
302
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 101 So Potomac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE		First ELIZABETH	Middle DAVIS	Last DAVIS	4. DATE OF DEATH Oct 21 1956	Month Oct	Day 21	Year 1956	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 11 1874	9. AGE (In years from last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Keedsville Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Norris		14. MOTHER'S MAIDEN NAME Mary Lapole							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Viola M. Burger 445 Frederick St		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver		DUE TO		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 6 MOS.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Hypertensive Arteriosclerotic Heart Disease 8 years							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 148 N. Potomac St., Hagerstown, Md.		20f. (City or town) Hagerstown		(County) Hagerstown	(State) Md.
21. I certify that I attended the deceased from 11.26.49 , 19, to 10.21.56 , 19, that I last saw the deceased alive on 10.21.56 , 19, and that death occurred at 7:00PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 148 N. Potomac St., Hagerstown, Md.		DATE SIGNED 10.22.56	
ACTUAL SIGNATURE 									
PHYSICIAN'S NAME (Type) S. Earl Young M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS				24a. REC'D BY REGISTRAR Oct. 24. 1956		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

CT 3 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10705

10750

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONS BORO		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 10 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		d. STREET ADDRESS KNOXVILLE MD. R. I.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY E	First	Middle	Last
4. DATE OF DEATH OCTOBER 22 1956	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH SEPTEMBER 27 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ROHRERSVILLE WASH. CO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH DEENER		14. MOTHER'S MAIDEN NAME ANN REBECCA STINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 681-3	
17. INFORMANT LEE DEENER		Address Boonsboro MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10 1956 to Oct. 22 1956 that I last saw the deceased alive on October 22 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro			
ACTUAL SIGNATURE G. W. Le Van		DATE SIGNED 10/23/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 25 1956	
22c. NAME OF CEMETERY OR CREMATORIAL CHURCH OF BRETHREN CEMETERY		22d. LOCATION (City, town, or county) BROWNSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE LAST FUNERAL HOME		ADDRESS Boonsboro MD.	
24a. REC'D BY REGISTRAR John H. Rad		24b. REGISTRAR'S SIGNATURE DATE Oct. 25 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please retain carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

OCT 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10706

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 60 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 208 Willard St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) First Middle Last		d. STREET ADDRESS 208 Willard St.	
John Alexander Delosier		4. DATE OF DEATH October 28	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 29, 1876	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fair Board	
11. BIRTHPLACE (State or foreign country) Smithsburg Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Delosier		14. MOTHER'S MAIDEN NAME Minerva Densmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. A 17. INFORMANT 214-09-0315 Mrs. Opal Delosier Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO acute cerebral Hemorrhage 6hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —	
(County) —		(State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		DATE SIGNED 10-29-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31- 56	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR R. 2. 1956		24b. REGISTRAR'S SIGNATURE Charles H. Powers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deferral necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALAU V. B.

1956

THE NEW EDITION

Maryland State Department of Health—Baltimore, 18

File # 2 Wells & D. O. M. E
Death Cert. No. 11-1-56

10707

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		10701 Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hagerstown 3 days		a. STATE Penna.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle		b. COUNTY Franklin	
3. NAME OF DECEASED (Type or print) SARAH		First C.	Middle	Last PETRICH	4. DATE OF DEATH Oct. 27 1956
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Greencastle, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jesse E. Stine		14. MOTHER'S MAIDEN NAME Mary S. Unger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No		16. SOCIAL SECURITY NO.		17. INFORMANT Earl Stine Baltimore 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Source: furnace		Carbon Monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH 342 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall to the floor, restriction of respiration			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10-27-56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Greencastle, Franklin Penna					
21. I certify that I attended the deceased from 9/1 1939, to 10/27 1956 that I last saw the deceased alive on 10/26 1956, and that death occurred at 5:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) W. C. Bowers, M.D. Greencastle, Pa.					
22a. BURIAL OR CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/56		22c. NAME OF CEMETERY OR CREMATORIUM Green Hill	
22d. LOCATION (City, town, or county) Waynesboro, Pa.					
23. FUNERAL DIRECTOR'S SIGNATURE A. M. Bowers		ADDRESS Greencastle, Pa.		24a. REC'D BY REGISTRAR Nov. 2, 1956	
				24b. REGISTRAR'S SIGNATURE W. C. Bowers	

REGELY E.

NOV 5 1956

REGELY E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10751

CERTIFICATE OF DEATH

Reg. Dist. No.

10708
302

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANVILLE		c. LENGTH OF STAY IN 1b 4 YRS.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MENNONITE HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANVILLE		d. STREET ADDRESS 'MENNONTIE HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CHRISTIAN		First R.		Middle EBY		4. DATE OF DEATH OCTOBER	Month 6	Day 19	Year 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1881	9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME CLAM EBY		14. MOTHER'S MAIDEN NAME ELIZABETH RIFE										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, No, or unknown] NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS EARL SHANK		Address RT. #3 HAGERSTOWN MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c)		Arterio sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral benign				years								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN	(County) MCGOVERN	(State) MD.
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>6 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 Oct</u> , 19 <u>56</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state)		DATE SIGNED 10/7/56		
ACTUAL SIGNATURE E. Earl S. Boulden M.D.												
22a. BURIAL, CREMATION, CASKET (Specify) BURIAL		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORIAL REIFF CHURCH CEM.		22d. LOCATION (City, town, or county) WASHINGTON CO. MD.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Normant, Hagerstown, Md.		ADDRESS Hagerstown, Md.		24a. REC'D. BY REGISTRAR Oct. 8, 1956		24b. REGISTRAR'S SIGNATURE John H. Bowers						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y-8

OCT 10 1968

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director,
 page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752

CERTIFICATE OF DEATH

10709

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural		c. LENGTH OF STAY IN 1b Hagerstown 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		RFD #2		d. STREET ADDRESS		Hagerstown			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				RFD #2					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Margaret		Helena	Flegel		Oct. 3,			19 56	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 62	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.	
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 28, 1894	62 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or Foreign country) Emmitsburg, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Long		14. MOTHER'S MAIDEN NAME Annie Grottle							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marvin Dietrich, Maugansville, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Acute myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH June 1-1956			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		{ (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from		June 1956		to Oct. 3 1956		that I last saw the deceased alive on Oct. 3 1956, and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 16-4-56			
PHYSICIAN'S NAME (Type)		F. F. F. to w. m. a.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-6-56		22c. NAME OF CEMETERY OR CREMATORIY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Oct. 8, 1956		24b. REGISTRAR'S SIGNATURE Shane H. Bowser			

BUPEAU Y E

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10702 CERTIFICATE OF DEATH

Dr Binford

Reg. Dist. No. 303

10710

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 31 So Prospect St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GERTRUDE	Middle LAVINIA	Last GEORGE	4. DATE OF DEATH Oct 19 1956	Month Year 19	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 19 1873	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS Days 0	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Sharpsburg Wash. Co Md USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob C. Grove				14. MOTHER'S MAIDEN NAME Elizabeth Mumma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None 17. INFORMANT Miss Frances Mumma Hagerstown Md. Address 31 So Prospect St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Myelogenous Leukemia 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Cardiovascular Disease							
20a. ACCIDENT <input type="checkbox"/> UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 October 1956 to 19 October 1956 that I last saw the deceased alive on 19 October 1956 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard T. Binford		ADDRESS (Street, city or town, state) Hagerstown, Md. 21 Oct. 1956 DATE SIGNED					
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		1135 POTOMAC AVE., HAGERSTOWN, MARYLAND 21 OCT. 1956					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10-22-56		22b. DATE THEREOF 10-22-56		22c. NAME OF CEMETERY OR CREMATORIAL Linwood Cemetery Haverhill Essex Co Mass		22d. LOCATION (City, town, or county) (State) Essex Co Mass	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Det. 22, 1956		24b. REGISTRAR'S SIGNATURE Richard T. Binford	

TO HOSPITAL may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours of death. Page 4

BUREAU Y

OCT 4 1956

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10753 10711

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10753				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
1. PLACE OF DEATH a. COUNTY		MARYLAND		a. STATE		b. COUNTY					
in son				Md		Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Spring		7 Yrs		Clear Spring							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?					
no r. n. in. Co.				new Lincoln Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF -DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
EDWARD		STOUT	FR	HAGER	October	8	1956	19			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years from birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.				
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	November 29 1904	51 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
TAX COLLECTOR						Old Forge Pa.			U.S.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
George Harry Hager			Gertrude V. Stouffer								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
			216-01-8518			George Hager					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Partial evulsion of skull and brain tissue</u> DUE TO <u>due to shotgun wound (16 gauge)</u> INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED?											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shotgun (16 gauge)</u>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u>10</u> p.m. Oct. 8 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
				on farm		R# 2 Clear respirng		Wash		Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 10-9-56	
EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Cremation		Oct. 10 1956		Baltimore Cemetery		Baltimore		Md			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Andrew V. Wells, Funeral Director				Oct 15 1956							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU
OCT 15 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10712

302

10703

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL, OR ATTENDING PHYSICIAN: I am required that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-peg carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) HARRY		First Last HALE	Middle Month Oct. Day 21 Year 1956
4. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1885
9. AGE (in years from last birthday) 71		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Western MD.R.R	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
13. FATHER'S NAME Francis Hale		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-09-8992	17. INFORMANT Mrs. Lillian E. Everhart
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease		19. ADDRESS Rowe St. Hagerstown, Md.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cardiac decompensation		20. INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tumour pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that I attended the deceased from <u>Oct. 18</u> , 1956, to <u>Oct. 21</u> , 1956, that I last saw the deceased alive on <u>Oct. 21</u> , 1956, and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE EDWARD W. DITTO, M.D.		ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Edward W. Ditto, M.D.		DATE SIGNED 10/23/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 25, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 25, 1956	
Wm. O. Morris C-1100		24b. REGISTRAR'S SIGNATURE L. H. St. Gowers	

SAUPEAU V. S

OCT 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

10704

CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE	
WASHINGTON MARYLAND		MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CLEARSPrING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R. #1	
WASHINGTON Co. HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LESTER	Middle R Hawbaker
4. DATE OF DEATH		Month October	Day 10
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
MALE		WHITE	8. DATE OF BIRTH Sept. 30, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MERCERSBURG, PA. R.D.
FARMER		GEN. FARMING	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
SAMUEL N. HAWBAKER		SARAH HAWBAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	17. INFORMANT
No		214-09-7351	Address Creston Hawbaker, Mercersburg, Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Infective Endocarditis	
421.4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		2 weeks	
DUE TO (b)		Chronic Valvular Disease	
DUE TO (c)		15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 25, 1956, to Oct. 10, 1956, that I last saw the deceased alive on Oct. 9, 1956, and that death occurred at 5:40 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 10/10/56	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		David R. Brewer M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/13/56	22c. NAME OF CEMETERY OR CREMATORIAL WELSH Run BRETHERN
22d. LOCATION (City, town, or county) FRANKLIN Co., MERCERSBURG, PA. R.D.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Young, Mercersburg, Pa.		24a. REC'D BY REGISTRAR Oct. 12, 1956	24b. REGISTRAR'S SIGNATURE David R. Brewer

BUREAU V. S.

OCT 15 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 15-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10714

10705 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Washington	MARYLAND	Penna. COUNTY Franklin
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Hagerstown	1 day	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Wash. Co. Hosp.	STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH Oct. 15, 1956	
MARY C. HECKMAN		IF UNDER 1 YEAR Months Days Hours Min.	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Fem.	WHITE	Widow	Nov. 27, 1865
9. AGE last birthday yrs.	90	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY	own Home	11. BIRTHPLACE (State or foreign country)	
Housekeeper		St. Thomas, Pa. L. I.	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Isaac Eber		215A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if unk.)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Anne Mary Heckman, Lemasters, Pa.		INTERVAL BETWEEN ONSET AND DEATH 80 yrs.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) Chronic Rheumatic Heart Disease	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/11, 1929, to 10/15, 1956, that I last saw the deceased alive on 10/15, 1956, and that death occurred at 12:45 P.M. from the causes and on the date stated above. SIGNATURE <i>John Greenough M.D.</i> ADDRESS (Street, city, town, state) <i>Greenough Ave 10/16/56</i> DATE SIGNED <i>10/16/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM
Burial		10/18/56	St. Thomas Cem.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
Oct. 16, 1956		G. H. Powers	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
F. H. Turner, Mercersburg, Pa.			

BUREAU Y.

OCT 18 1956

RECEIVED

may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH Dr. Hocklin & Bowers. 10715
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Vt.		b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, 2-3 town		c. LENGTH OF STAY IN 1b 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BRUCE	Middle MONROE	Last HELM	4. DATE OF DEATH Oct 15 1956	Month 10	Day 15	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7 1910		9. AGE (In years from last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Fox Company		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Wayneboro Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Helm				14. MOTHER'S MAIDEN NAME Annie Reecher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Carleton Helm		Address 115 W. Washington St. Baltimore 1, Md. 21201	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> INTERVAL BETWEEN DUE TO <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arterio sclerotic heart disease</u> 1.5 years (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1956, to <u>Oct</u> , 1956, that I last saw the deceased alive on <u>15 Oct</u> , 1956, and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 W. Washington St. Baltimore 1, Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>Eldon D. Hocklin, M.D.</u> 10/16/56 PHYSICIAN'S NAME (Type) <u>Eldon D. Hocklin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-56		22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. H. C. Hocklin, M.D.				ADDRESS		24a. REC'D. BY REGISTRAR Oct 18, 1956	
						24b. REGISTRAR'S SIGNATURE Charles Bowers	

BEAUV. S.

20T 2 1956

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707

CERTIFICATE OF DEATH

10716

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. CITY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Big Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Big Spring RFD #1		d. DATE OF DEATH October 24		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel Dailey Henson		First Middle Last		Month October		Year 1956	
4. SEX Male		5. COLOR OR RACE White		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH October 11, 1885	
8. AGE (In years last birthday) 71		9. IF UNDER 1 YEAR Mo 0 Days 13		10. IF UNDER 24 HRS Hours 13 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dam # 4 Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Henson				14. MOTHER'S MAIDEN NAME Annie R. Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Cora Eva Henson		Address Big Spring RFD#1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 2 years							
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1955, to Oct. 24, 1956, that I last saw the deceased alive on October 24, 1956, and that death occurred at 2:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Leah Robert Cohen, M.D.							
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				Clear Spring, Md.		10/26/56	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF October 28, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Pinesburg Mennonite		22d. LOCATION (City, town, or county) Pinesburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		ADDRESS		24a. REC'D BY REGISTRAR Oct. 27, 1956		24b. REGISTRAR'S SIGNATURE Leah H. Powers	

TO HOSPITAL
may be
by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

CHATEAU V. G.

1956

CHATEAU V. G.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10717

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 30 N. Walnut St.,		d. STREET ADDRESS 30 N. Walnut St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Benjamin	Middle Franklin	Last Hilliard			
4. DATE OF DEATH	10	Month	Day			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 13, 1891	65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY W. Md. R. R.		11. BIRTHPLACE (State or foreign country) Clark County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Hilliard		14. MOTHER'S MAIDEN NAME Fanny Lee				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-12-2083		17. INFORMANT Mrs. Esther Hilliard		Address Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchial pneumonia				INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b		DUE TO				
DUE TO c						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		alcoholism				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Hour o. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —
(County) —		(State) —				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10-16-56
EXAMINER'S NAME (Type) S. Robert Wells, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-17-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown, Md.
(State) —						
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 18, 1956		24b. REGISTRAR'S SIGNATURE Donald J. Davies

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any detail is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

GERALD V. S

OCT 22 1966

REGISTRATION

10718

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709 **CERTIFICATE OF DEATH**

Rd E. W. Ditto 111
Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 17 Mos		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg R # 2		d. STREET ADDRESS Chewsville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELVIA RAY HOOVER		First	Middle	Last	4. DATE OF DEATH Oct 20 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 9 1883	9. AGE (In years from birth) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer- Owner		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Chewsville Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Levi Hoover		14. MOTHER'S MAIDEN NAME Sarah Easterday		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs Katie E. Hoover Smithsburg R # 2 Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro - vascular Accident		DUE TO 445X		INTERVAL BETWEEN ONSET AND DEATH 12 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO Hypertensive Cardi - vascular		(c) DUE TO chisease		20 yr.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Benign Prostatic hypertrophy				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 217 W. Washington St.	(County) Hagerstown	(State) Md.			
21. I certify that I attended the deceased from Sept 18, 1956 , to Oct 20, 1956 , that I last saw the deceased alive on Oct 19, 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 217 W. Washington St.		DATE SIGNED 10/22/56			
ACTUAL SIGNATURE Edward W. Ditto									
PHYSICIAN'S NAME (Type) Edward W. Ditto 111, M.D.		21c. NAME OF CEMETERY OR CREMATORIUM Cemetery Mausoleum Smithsburg		22d. LOCATION (City, town, or county) Smithsburg Wash. Co Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMA					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Oct 24, 1956		24b. REGISTRAR'S SIGNATURE W. H. Coffman			

BUREAU V 8

1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10710

CERTIFICATE OF DEATH

10719

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 59 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339 Jefferson St.		d. STREET ADDRESS 339 Jefferson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Max		First McPherson	Middle Hose
4. DATE OF DEATH Oct. 21		Month Oct.	Day 21
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 28, 1896		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. IF UNDER 24 HRS Hours Min.	
13. FATHER'S NAME William H. Hose		14. MOTHER'S MAIDEN NAME Margaret E. Baughman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5160	
17. INFORMANT Miss Mary Hose		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease with DUE TO congestive failure 2 years INTERVAL BETWEEN ONSET AND DEATH 2 years Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on Oct. 21, 1956, and that death occurred at 9:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE B. B. Kneisley, M.D.		ADDRESS (Street, city or town, state) 148 West Washington St., Hagerstown, Maryland DATE SIGNED 10/22/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-56	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Linnich & Son		24a. REC'D BY REGISTRAR Oct. 25, 1956	24b. REGISTRAR'S SIGNATURE B. H. Powers

TO HOSPITAL
may be referred
TO FUNERAL
CERTIFICATE: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

101 176

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1071

CERTIFICATE OF DEATH

Reg. Dist. No.

1070
302

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2Y-7M-2S		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ZETTLERSTOWN - RURAL		d. STREET ADDRESS MIDDLETON MD. R. 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLICK NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPH		First C.	Middle HUTZELL	Last HUTZELL	4. DATE OF DEATH OCTOBER - 9 - 1956	Month OCTOBER	Day 9	Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 12 - 1869	9. AGE (in years lost birthday) 87 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT RETIRED GENERAL STORE		10b. KIND OF BUSINESS OR INDUSTRY WASH. CO. MD		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SAMUEL HUTZELL		14. MOTHER'S MAIDEN NAME ELIZABETH LAPOLI				Address HAGERSTOWN MD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. JACK L. BAKER - 201 E. FRANKLIN ST		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Carcinoma Nasal Sinus</i> 3 yrs		
						INTERVAL BETWEEN ONSET AND DEATH		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 10-1 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro Cemetery		20f. (City or town) (County) (State) Boonsboro MD		
21. I certify that I attended the deceased from 10-1-1956 to 10-9-1956 , that I last saw the deceased alive on 10-3-1956 , and that death occurred at 4 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. W. E. Smith</i> M.D.		ADDRESS (Street, city or town, state) Boonsboro MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 11, 1956		22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) Boonsboro WASH. CO. MD		
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME		ADDRESS Boonsboro MD		24a. REC'D BY REGISTRAR DATE 10-13-1956		24b. REGISTRAR'S SIGNATURE Smith Bowers		

LENEAU V. L.

1956

LENEAU V. L.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10712 CERTIFICATE OF DEATH

10721
302

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Hagerstown		STATE Pennsylvania COUNTY Neville Township	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pittsburgh, 25 STREET ADDRESS 7408 Yale Avenue	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
CHARLES HENRY INGRAM		October 17, 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widower	8. DATE OF BIRTH Jan. 17, 1891
9. AGE last birthday 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if Maintenance Man Ret. Township)	11. BIRTHPLACE (State or foreign country) Hyndman, Penna.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Washington Ingram	14. MOTHER'S MAIDEN NAME Estella Marian Johnson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Mrs. Lester Waters RT #1, Harpers Ferry, West Va.	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 years	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Diabetes Mellitus ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Intestinal obstruction 2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21g. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from Oct 14, 1956, to Oct 17, 1956, that I last saw the deceased alive on Oct 17, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above. SIGNATURE Paul Harrison M.D. 318 N. Potomac Hagerstown Md 10/17/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/20/56	NAME OF CEMETERY OR CREMATORIUM Samples Manor Cemetery Samples Manor, Maryland
24. REC'D BY REGISTRAR Oct. 22, 1956		REGISTRAR'S SIGNATURE G. H. Powers	LOCATION (City, town, or county) (State)
25. FUNERAL DIRECTOR'S SIGNATURE H. Ronald Eackles		ADDRESS ADDRESS Harpers Ferry West Va.	

BUREAU V. S.

DEC 1 1955

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10751 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10722

305

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission)		a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Mousetown		d. STREET ADDRESS	
Rural Mousetown		45 yrs		Rural Mousetown		R # 2 Boonsboro, Md.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R # 2 Boonsboro, Md.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Sadie Helen Catherine Itnyre					October 1			1956	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 28, 1975	81 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		Washington Co., Md.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Samuel Hutzell		Elizabeth Lapole							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		—		none		Grayson Itnyre- R # 2 Boonsboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd & 3rd degree burns to entire body DUE TO upper and lower extremities									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
none									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Caught on fire while sitting in chair smoking a pipe							
20c. TIME OF INJURY Month, Day, Year Hour 7:30 a.m. Oct 1 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) Rural Boonsboro, Wash		(County) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED 10-1-56							
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-56		22c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery		22d. LOCATION (City, town, or county) Boonsboro, Wash Md			
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home- Boonsboro, Md.		24a. REC'D BY REGISTRAR DATE Oct 3, 1956							
		24b. REGISTRAR'S SIGNATURE <i>John W. Ball</i>							

2000 ft

OCT 8 1956

1000 ft

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(S)
SM 9/55

10723
Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1331 Jefferson Blvd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ANIE		4. DATE OF DEATH Month October Day 15 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1888
9. AGE (in years from birthday) 67 yrs.		10. IF UNDER 1YEAR Months 11 Days 25	11. IF UNDER 24 HRS. Hours 11 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Clear Spring, Maryland	
11. BIRTHPLACE (State or foreign country) Clear Spring, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Mummert		14. MOTHER'S MAIDEN NAME Lavinia Beard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lester Keyser		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Body found in cistern at residence	
20c. TIME OF INJURY Month, Day, Year Hour <u>XXX</u> p.m. Oct. 15 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED 10-16-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/1956	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Ringer		24a. REC'D BY REGISTRAR Oct. 20, 1956	
ADDRESS Hagerstown, Maryland		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>	

2. REAU V. 8

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10724

10714

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <i>WASHINGTON</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>PENNA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HANFORD</i>		b. COUNTY <i>FRANKLIN</i>	
c. LENGTH OF STAY IN 1b <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHAMBERSBURG</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HANFORD HOSPITAL</i>		d. STREET ADDRESS <i>547 OAK ST.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ALICE</i>	Last <i>Kotch</i>
4. DATE OF DEATH	Month <i>OCT.</i>	Day <i>1</i>	Year <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 8, 1923</i>
9. AGE (In years last birthday) <i>33 yrs.</i>		10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AIR-RAFT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FAIRCHILD AIRCRAFT</i>	11. BIRTHPLACE (State or foreign country) <i>CHAMBERSBURG PA</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>CHARLES TRLETT</i>	14. MOTHER'S MAIDEN NAME <i>MARY SHATZER</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>	16. SOCIAL SECURITY NO <i>195-16-3912</i>	17. INFORMANT <i>WILLIAM J. KOTCH</i>	Address <i>547 OAK ST CHAMBERSBURG, PA</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous subarachnoid hemorrhage</i>			
DUE TO <i>330x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>—</i>			
DUE TO <i>—</i>			
C (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Essential hypertension</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) <i>—</i>		(County) <i>—</i>	
(State) <i>—</i>			
21. I certify that I attended the deceased from <i>Sept. 21, 1956</i> , to <i>Oct. 1, 1956</i> , that I last saw the deceased alive on <i>Oct. 1, 1956</i> , and that death occurred at <i>9:12p M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>			
DATE SIGNED <i>10/2/56</i>			
ACTUAL SIGNATURE <i>L. L. Packard</i>			
M.D. <i>—</i> 115 E. Franklin St.			
PHYSICIAN'S NAME (Type) <i>L. L. Packard, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/4/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Corpus Christi</i>
22d. LOCATION (City, town, or county) <i>Chambersburg</i>		(State) <i>Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sugar-Kouzer Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Oct. 6, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Robert Kouzer</i>
ADDRESS <i>Hagerstown, Md.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

CERTIFICATE OF DEATH

10725

308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 S. Prospect St.		d. STREET ADDRESS 221 S. Prospect St.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frederick Middle Julius Last Lenzen		4. DATE OF DEATH Month October Day 24, 1956 Year					
5. SEX male white		6. COLOR OR RACE 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 12, 1900		9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector		10b. KIND OF BUSINESS OR INDUSTRY aircraft industry		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lenzen		14. MOTHER'S MAIDEN NAME Ella Wise					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 141-14-4065		17. INFORMANT Mrs. Florence Lenzen, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma of Bronchus				INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1947, to Oct. 24, 1956, that I last saw the deceased alive on Oct. 24, 1956, and that death occurred at 6:05 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Philip J. Hirshman PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) M.D. 159 Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 10-27-56		22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Linnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Oct. 29, 1956		24b. REGISTRAR'S SIGNATURE G. H. Bowers	

TO HOSPITAL ATTENDING PHYSICIAN: That I am relieved that the death certificate be executed within 21 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please sign carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

OCT 21 1956

REGGIE VEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10755

CERTIFICATE OF DEATH

10726
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>2 months 12 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		d. STREET ADDRESS <i>251 Fredrick Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>				4. DATE OF DEATH Month <i>October</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Laura</i>		First	Middle	Day <i>19</i>	Year <i>1956</i>	Month <i>25</i>	Year <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1890</i>	9. AGE (In years last birthday) <i>66</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>24</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lebanon, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Donmoyer</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Lear</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Catherine SAGE Hancock, Md.</i>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>19 days</i>	
440X DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hypertensive cardiovascular disease</i>		7 years			
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic glomerular nephritis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 25 1956</i> , that I last saw the deceased alive on <i>October 25 1956</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. B. Kneisley</i>		ADDRESS (Street, city or town, state) <i>148 West Washington Street</i>		DATE SIGNED <i>10/26/56</i>			
PHYSICIAN'S NAME (Type) <i>B. B. Kneisley, M.D.</i>		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/29/1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Hagerstown, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Suter-Houzer Funeral Home</i>		ADDRESS <i>Hagerstown, Maryland</i>		24a. REC'D. BY REGISTRAR <i>Oct. 30, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Powers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. E. Litto Jr

10727

10716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 Yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestertown		d. STREET ADDRESS 1215 Walnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LARY		First ELIZABETH	Middle LOWERY	Last	4. DATE OF DEATH Oct 13 1956	Month 10	Day 13	Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 2 1883	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chestertown		12. CITIZEN OF WHAT COUNTRY? None					
13. FATHER'S NAME Willie Meadows		14. MOTHER'S MAIDEN NAME Alice McCoy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None			16. SOCIAL SECURITY NO. None			17. INFORMANT Clifford Lowery	Address Richmond, Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c)		19. INTERVAL BETWEEN ONSET AND DEATH 64 days									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>10-11-56</u> , 19, to <u>10-13</u> , 1956, that I last saw the deceased alive on <u>10-12-56</u> , 19, and that death occurred at <u>Chestertown</u> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. E. D. Dill</u> PHYSICIAN'S NAME (Type) <u>J. E. D. Dill</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>10/13/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORIUM Chestertown Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md., Co. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Worrell		ADDRESS 1215 Walnut St.		24a. REC'D BY REGISTRAR Oct. 17, 1956		24b. REGISTRAR'S SIGNATURE Bhart Gowess					

REAU Y.

CT 19 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10728

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 200 Mealey Parkway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Conv. Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Roy	Middle C.	Last Lowman	4. DATE OF DEATH Oct. 4 1956	Month Oct.	Day 4	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-26-1876	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Days 2	12. HOURS Hours 13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Webster Lowman				14. MOTHER'S MAIDEN NAME Mary C. Woessner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-07-7918		17. INFORMANT Mrs. Robert Treisler, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SICK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage Hypertensive Vascular Disease Atherosclerosis, Generalized							
INTERVAL BETWEEN ONSET AND DEATH 13 days 3 yrs. 3 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 30, 1953, to Oct. 4, 1956, that I last saw the deceased alive on Oct. 3, 1956, and that death occurred at 10 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Philip J. Hirshman, M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-6-56		22b. DATE THEREOF 10-6-1956		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE SUTERA-ROUZEA FUNERAL HOME P. Stanley Rouzer		ADDRESS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR Oct. 6, 1956		24b. REGISTRAR'S SIGNATURE G. H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

BUREAU Y. S.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10729

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb few minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. 40 east $\frac{1}{2}$ mile from Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	

3. NAME OF DECEASED (Type or print)		First JOHN	Middle JAMES	Last MARKEY	4. DATE OF DEATH October	Month	Day 12	Year 1956
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5. SEX White	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1916	9. AGE (In years at birthday) 40 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 16	Hours	Min.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>						

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Sargent	10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	11. BIRTHPLACE (State or foreign country) Philadelphia, Penn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John J. Markey	14. MOTHER'S MAIDEN NAME Ann Moore
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Erika Lattern Markey	Address Cumberland, Md.
Yes			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushed Skull - Hemorrhage & Shock</u>		
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car that crashed with truck and was pinned under truck
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20c. TIME OF INJURY Hour 7:40 a.m.	Month, Day, Year 10-12 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Highway	20f. (City or town) Rural -Hagerstown, Wash	(County) Md	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 10-13-56
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EXAMINER'S NAME (Type) S. Robert Wells, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/16/1956	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	22d. LOCATION (City, town, or county) Arlington, Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE Superior Funeral Home R. Franklin Powers	ADDRESS Hagerstown, Maryland	24a. REC'D BY REGISTRAR Oct. 13, 1956	24b. REGISTRAR'S SIGNATURE <i>Robert Powers</i>
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LEAVY, A.

3 1956

LEAVY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10718

CERTIFICATE OF DEATH

10731
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON								
c. LENGTH OF STAY IN 1b 13 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK RURAL								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. & HOSPITAL		d. STREET ADDRESS HAGERSTOWN MD. R. 13								
3. NAME OF DECEASED (Type or print) MARY - LOUISE - MARTIN		First	Middle							
Last		4. DATE OF DEATH OCTOBER - 19 - 1956	Month	Day	Year					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-28-1870	9. AGE (In years lost birthday) 81-2-21/yr.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P-TIRED SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) BEAVER CREEK MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME ALBERT B. MARTIN		14. MOTHER'S MAIDEN NAME ANN M. TROUPE		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT MISS MARY SHAFFER HAGERSTOWN MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebral thrombosis (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardio-vascular disease			20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 4, 1956, to Oct. 19, 1956, that I last saw the deceased alive on Oct. 19, 1956, and that death occurred at 7:27 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Ditto		ADDRESS (Street, city or town, state) M.D. 217 W. Washington St.			DATE SIGNED 10/20/56					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 22 1956		22c. NAME OF CEMETERY OR CEMETORY FUNKSTOWN CEMETERY		22d. LOCATION (City, town, or county) HAGERSTOWN WASH. CO MD				
23. FUNERAL DIRECTOR'S SIGNATURE BAPT FUNERAL HOME Boonsboro MD.		ADDRESS Boonsboro MD.		24d. REC'D BY REGISTRAR Oct. 24 1956		24e. REGISTRAR'S SIGNATURE West Bowers				

BUETAU V. C.

OCT 20 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
11751
12-28-56
S. Robert Layman, M.D. 56
Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 30 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) ROBERT		First ALBERT	Middle MECHLING
4. DATE OF DEATH Month OCTOBER	Day 17	Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1898
9. AGE (In years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY AUTO ACCESSORY RETAIL STORE	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. W.W.#1	17. INFORMANT MRS. PAULINE MECHLING
		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage/right fronto-parietal</i> DUE TO <i>area with extension to subarachnoid space</i>			
INTERVAL BETWEEN ONSET AND DEATH 47 days			
13x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b), (c) <i>Thromb/ head injury</i> DUE TO <i>Hypertensive cardiovascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH 26 47 days 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive cardiovascular disease</i> <i>Arteriosclerotic Heart Disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ladder while at work.	
20c. TIME OF INJURY 11:400 a.m. p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sears Roebuck Store
		20f. (City or town) Hagerstown	
		(County) Wash. Md. (State)	
21. I certify that I attended the deceased from <u>October 1, 1956</u> to <u>October 17, 1956</u> , that I last saw the deceased alive on <u>October 17, 1956</u> , and that death occurred at <u>8:08 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 100 Professional Arts Bldg. 10-19-56 DATE SIGNED			
ACTUAL SIGNATURE <i>W. J. Layman</i>			
PHYSICIAN'S NAME (Type) William T. Layman, M.D. Hagerstown Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/20/56	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Layman, Hagerstown Md.</i>			
ADDRESS <i>W. J. Layman, Hagerstown Md.</i>		24a. REC'D BY REGISTRAR <i>Oct. 22, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. Layman, Hagerstown Md.</i>

BUREAU V. S

OCT 31 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10720

CERTIFICATE OF DEATH

10732

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Quincy Twp.	
3. NAME OF DECEASED (Type or print)	First RALPH	Middle MENTZER	4. DATE OF DEATH Oct. 28, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 8, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	9. AGE (in years last birthday) 34 yrs.
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry J. Mentzer		14. MOTHER'S MAIDEN NAME Bessie Forthman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. NW II 191-16-7936	17. INFORMANT Mrs. Ralph Mentzer, RD # 1, Waynesboro, Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
(b) DUE TO Hypertension, Cardiovacular Disease		17 yrs.	
(c) DUE TO Arteriosclerosis, Cerebral		19 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		M.D. Hagerstown, Md., Oct. 28, 1956	
PHYSICIAN'S NAME (Type)		H. J. Mentzer, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/56	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Quincy Twp., Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE St. Marlin BOE		ADDRESS Waynesboro, Penna.	
24a. REG'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Charles Bowers	

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OCT 31 1956

REV. H. G. E.

10733

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 305

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 16 few minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Boonsboro, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville,	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle J.	Last Mitchell
4. DATE OF DEATH	Month Oct.	Day 12	Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 15, 1890
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
66 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Boonsboro		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mitchell		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) W W I		16. SOCIAL SECURITY NO. War I 212-16-8047AB	
17. INFORMANT		Address Mrs. Pauline Mitchell - wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple open fractures lower extremities DUE TO Punctured wound abdominal cavity Conditions, if any, which gave rise to immediate cause (b) (Hemorrhage and shock) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pedestrian hit by oncoming car while walking in line of traffic	
20c. TIME OF INJURY Hour 7:15 p. m.		Month, Day, Year Oct. 12 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Highway Rural-Boonsboro, Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	DATE SIGNED 10-15-56		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (See 1b) Burial	22b. DATE THEREOF Oct. 15, 1956	22c. NAME OF CEMETERY OR CEMETORY Boonsboro Cemetery	22d. LOCATION (City, town, or county) (State) Boonsboro Wash. Co. MD.
23. FUNERAL DIRECTOR'S SIGNATURE BAPT FUNERAL HOME	ADDRESS Boonsboro, Maryland	24a. REC'D BY REGISTRAR DATE Oct. 15, 1956	24b. REGISTRAR'S SIGNATURE <i>John H. Bapt</i>

BUJALAJ V

1356



10734

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film 0205 10-17-56 et
CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harper's Ferry, W. Va. Rural		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Minnie	Middle May	Last Moore
4. DATE OF DEATH	Month 10	Day 5	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1868
9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Reid		14. MOTHER'S MAIDEN NAME Susan Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Nellie Hovermale, Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelo-nephritis			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ?			
DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Sharpsburg (State) Md.	
21. I certify that I attended the deceased from 8/27/56 , 19, to 10/5/56 , 19, that I last saw the deceased alive on 10/4/56 , 19, and that death occurred at 4 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 10/5/56			
ACTUAL SIGNATURE <i>Walter H. Shirley</i>		PHYSICIAN'S NAME (Type) Walter H. Shirley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-1956	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bob Miller</i>		24a. REC'D BY REGISTRAR DATE 10/8/1956	
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10735

10721

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edgar	Middle Bruce	Last Morrison Sr.
4. DATE OF DEATH 10	Month JUN	Day 23	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1883
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) recovered		10b. KIND OF BUSINESS OR INDUSTRY W. Md. R.R.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward G. Morrison	
14. MOTHER'S MAIDEN NAME Anna Cover		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 705-10-5379		17. INFORMANT Mrs. Evelyn Morrison	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
DUE TO DUE TO DUE TO		Carcinoma Liver	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-56 to 10-22-56, that I last saw the deceased alive on 10-20-56, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE: Fred W. Kraiss M.D. PHYSICIAN'S NAME (Type): Fred W. Kraiss		ADDRESS (Street, City or town, state) Hagerstown, Md. DATE SIGNED Oct 26, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-25-56	
22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct 26, 1956		24b. REGISTRAR'S SIGNATURE B. H. Bowes	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

OCT 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10736
10722 CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Washington</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>587 West Church St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Luke's Church</u>										
3. NAME OF DECEASED (Type or print) <u>ELI A. WELLS</u>		First <u>ELI</u>	Middle <u>ALVIN</u>	Last <u>WELLS</u>	4. DATE OF DEATH <u>Oct 15 1956</u>		Month <u>Oct</u>	Day <u>15</u>	Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 7 1879</u>	9. AGE (In years lost birthday) yrs. <u>77 yrs</u>	10. IF UNDER 1 YEAR Months <u>0</u>	Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u>	12. IF UNDER 24 HRS. Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Gold</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Winkfield</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Helen W. Wells</u>		Address <u>115 N. Potomac Street, Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3X</u> arteriosclerotic hypertensive vascular disease										INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>
DUE TO <u>Chronic glomerular nephritis</u>										7 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial heart failure grade iv</u>										1 yr
DUE TO (c)										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>	
21. I certify that I attended the deceased from <u>Oct. 1, 1956</u> to <u>Oct. 15, 1956</u> , that I last saw the deceased alive on <u>Oct. 13, 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>S. Robert Wells</u>										ADDRESS (Street, city or town, state) <u>115 N. Potomac Street, Hagerstown, Maryland</u>
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>										DATE SIGNED <u>10-16-56</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>West Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown</u>		(State) <u>MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Wells</u>					ADDRESS <u>115 N. Potomac Street, Hagerstown, Maryland</u>					
					24a. REC'D BY REGISTRAR <u>Oct. 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Gowers</u>			

BUREAU V. 2

OCT 1952

REGULATIVE

may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. FRANK LUSBY
230 N. Potomac St
HAGERSTOWN MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10723

CERTIFICATE OF DEATH

10737
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 50 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS NO. 14 DOWNSVILLE ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NO. 14 DOWNSVILLE ROAD		d. STREET ADDRESS NO. 14 DOWNSVILLE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARVEY	Middle MILLARD	Last NUNAMAKER	4. DATE OF DEATH OCTOBER 18 1956	Month OCT	Day 18	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APR-14-1869	9. AGE (in years last birthday) 87-1-24 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - VICTOR PRODUCTS CORP. Retired		10b. KIND OF BUSINESS OR INDUSTRY NR. 13 BOONSBORO WASH. CO. MD. U.S.A.		11. BIRTHPLACE (State or foreign country) NR. 13 BOONSBORO WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME REASON NUNAMAKER		14. MOTHER'S MAIDEN NAME ELIZABETH HOFFMAN		Address 220-09-7875 SAMUEL NUNAMAKER 723 S. Potomac St. HAGERSTOWN MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 220-09-7875		17. INFORMANT SAMUEL NUNAMAKER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart disease	
DUE TO 420.0		DUE TO Myocarditis		DUE TO 360.0		INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 360.0		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 18 1952 to 18 Oct 1956 , that I last saw the deceased alive on 18 Oct 1956 , and that death occurred at 1130 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE F. F. Lusby		M.D. 230 N. Potomac St		ADDRESS (Street, city or town, state) Hagerstown MD		DATE SIGNED 19 Oct 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct 21 1956		22c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME		ADDRESS Boonsboro MD		24a. REC'D BY REGISTRAR Oct 24 1956		24b. REGISTRAR'S SIGNATURE Frank H. Boenard	

SAVANNAH

Oct 22 1959

100-271

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10738

10724

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 354 South Locust Street		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RUSSELL	Middle ROBERT	Last ORCUTT	4. DATE OF DEATH October	Month 4	Day 19	Year 56
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1903		9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY City of Hagerstown		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Orcutt			14. MOTHER'S MAIDEN NAME Myrtle Krider				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-09-2839		17. INFORMANT Mrs. Frances M. Orcutt		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis with Anginal</u> 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)
21. I certify that I attended the deceased from <u>9-24</u> , 1956, to <u>10-4</u> , 1956, that I last saw the deceased alive on <u>10-4</u> , 1956, and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. 998 Potomac Ave. Hagerstown, Md. 10-5-							DATE SIGNED
ACTUAL SIGNATURE <i>William M. Welty</i>	PHYSICIAN'S NAME (Type) Dalton N. Welty, M.D., Hagerstown, Md., Washington Co.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/7/56	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Mouzer Funeral Home R. Franklin Ringer	ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR Oct. 6, 1956		24b. REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Dr Hirshman
10739
Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Nursing Home				d. STREET ADDRESS 711 George St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH Oct 1 1963	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby 12 1875		9. AGE (In years (1st birthday) 81 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Johnsburg T. N.		12. CITIZEN OF WHAT COUNTRY? U. A.		
13. FATHER'S NAME George H. McGinnis		14. MOTHER'S MAIDEN NAME Nancy Cage						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert G. Ovelman Riverton		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Senile and arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)
21. I certify that I attended the deceased from Sept 11, 1950, to Oct 12, 1956, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 7:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 159-W. Washington St. Hagerstown		DATE SIGNED 10/13/63
ACTUAL SIGNATURE <i>Philip J. Hirshman</i>								
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/16/63		22b. DATE THEREOF 10/16/63		22c. NAME OF CEMETERY OR CREMATORIAL Levaville Cemetery		22d. LOCATION (City, town, or county) Levaville		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew V. Coffey Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Oct 19 1963		24b. REGISTRAR'S SIGNATURE Lenny M. Fochler Oct 20 1963		

BUREAU Y. S.

OCT 1 1940

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10740

10760

CERTIFICATE OF DEATH

Reg. Dist. No. 305...

1. PLACE OF DEATH.

COUNTY Washington

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Boonsboro

LENGTH OF STAY
(in this place)

6 Months

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Reeder's Nursing Home3. NAME OF
DECEASED:
(Type or Print)

(First) Oliver (Middle) B.

(Last) Palmer

5. SEX: Male

6. COLOR OR
RACE: White7. SINGLED, MARRIED,
WIDOWED, DIVORCED.
(Specify): Widowed8. DATE OF BIRTH:
Feb. 17, 18739. AGE last birthday
834. DATE (Month) (Day)
OF DEATH: October 6

10. BIRTHPLACE (State or foreign country): Maryland

11. CITIZEN OF WHAT
COUNTRY? USA10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Barber10B. KIND OF BUSINESS
OR INDUSTRY: Self-employed

13. FATHER'S NAME:

James Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service) No

16. SOCIAL SECURITY NO. Unk

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)
DUE TO

Coban Pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSE (S)

(B)
DUE TO

Generalized arteriosclerosis

10 years

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.(C)
DUE TO

Diabetes mellitus

5 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
White Not white
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1956, to Oct 6, 1956, that I last saw the deceased

alive on Oct. 5, 1956, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE
John PalmerADDRESS
BoonsboroDATE SIGNED
10/8/5623. BURIAL, CREMATION,
REMOVAL (SPECIFY)
BurialDATE THEREOF
9 Oct 1956NAME OF CEMETERY OR CREMATORIAL
Mountainview CemeteryLOCATION (City, town, or county)
Union Bridge, Maryland

(State)

DATE REC'D BY LOCAL
REGISTRAR
Oct 9, 1956REGISTRAR'S SIGNATURE
John F. Bax

24. FUNERAL DIRECTOR

N. R. Etchison & Son, Frederick, Md.

GUREAU V.

956 11 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

10725

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL: The law requires that the Death Certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Franklin	
c. LENGTH OF STAY IN 1b 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Waynesboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown Hospital		d. STREET ADDRESS Hagerstown #5	
3. NAME OF DECEASED (Type or print) Bertha		First Blanche	Middle Pepple
4. DATE OF DEATH Oct. 29, 1956		Month Oct.	Day 29
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11/1/1887		9. AGE (in years lost birthday) 68 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Wissinger		14. MOTHER'S MAIDEN NAME Emma Brenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT John R. Pepple, Hagerstown, Md., #5
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Pulmonary Embolism following: Cholecystectomy 2 wks ago. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertensive Cardiovascular Disease. (c)		Address INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 159 W. Washington St., Hagerstown, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <u>Oct 29, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Philip J. Hirshman</i>		DATE SIGNED M.D. 159 W. Washington St., Hagerstown, Md. 10/29/56	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/56	22c. NAME OF CEMETERY OR CREMATORIAL Green Hill	22d. LOCATION (City, town, or county) Waynesboro, Franklin, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip J. Hirshman, Waynesboro, Pa.</i>		24a. REC'D. DAY REGISTRAR Oct. 31, 1956	24b. REGISTRAR'S SIGNATURE <i>Franklin Bowers</i>

PUREAU V. S

NOV 2 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10742

10761

CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garroott's Mills		c. LENGTH OF STAY IN 1b 55 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural on farm		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Weverton	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillie	Middle Rosetta	Last Phillips
4. DATE OF DEATH	Month 10	Day 15	Year 1956
5. SEX	6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1883
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ U.S.A.	
13. FATHER'S NAME James A. Lowe		14. MOTHER'S MAIDEN NAME Kate Cross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -	
17. INFORMANT Wm. H. Phillips		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SICK - CARDIAC DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-15-1956 to 10-15-1956 that I last saw the deceased alive on 10-15-1956, and that death occurred at 4 P.M., from the causes and on the date stated above. ACTUAL M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 10-15-1956	
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 10-18-56	
22c. NAME OF CEMETERY OR CREMATORIAL Pentecostal		22d. LOCATION (City, town, or county) (State) Garroott's Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fuete		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE Katherine D. Hart	
ADDRESS Brunswick, Maryland			

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

ACT 21 1956

REGELY E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10762

CERTIFICATE OF DEATH

10743

Reg. Dist. No.

305

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HANCOCK, MD.

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BOONS BORO

c. LENGTH OF STAY IN 1b

27 YEARS

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

N. MAIN ST.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)64
yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

MALE

WHITE

WIDOWED DIVORCED

MAY 2-1842

64

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

BAKIER

OWN SHOP

CAVETOWN WASH. CO. MD.

U.S.A.

SILAS R. POUND

ELIZABETH SNECKENBERGER

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

NO.

16. SOCIAL SECURITY NO.

17. INFORMANT

215-34-3413 MRS. BERTHA POUND

Address

12. CITIZEN OF WHAT COUNTRY?

BAONS BORO MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

CARDIOVASCULAR COLLAPSE

INTERVAL BETWEEN
ONSET AND DEATH

min.

4.1.1.1

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Cardiac failure

yrs.

(c)

Arteriosclerotic Heart Disease

3 yrs.

4.1.1.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Pulmonary infarct in Feb. 1956

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY

(Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour

a. m.

p. m.

While
at workNot while
at work

21. I certify that I attended the deceased from

July 1955, to Oct 19

1955, that I last saw the deceased

alive on

Sept 12 1956

, and that death occurred at 4:30 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Louis G. Graff, M.D.

119 E. Antietam St.

10-19-56.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

Burial

Oct 22 1956

Boonsboro Maryland

Boonsboro

Wash. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(State)

BAST FUNERAL HOME

Boonsboro MD

Oct 22 1956

John H. Bast

John H. Bast

BURKE V. M.

ATT'D 1956

100-1111-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10763

CERTIFICATE OF DEATH

1074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport, Md</i>		c. LENGTH OF STAY IN 1b <i>Hospital</i>	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Carrie B. Provard</i>		d. STREET ADDRESS <i>136 Greenmount Ave</i>	
4. DATE OF DEATH <i>October 5 1956</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3, 1875</i>
9. AGE (In years, lost birthday) <i>81 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Waynesboro, Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel McPhern</i>		14. MOTHER'S MAIDEN NAME <i>Kathryn FITZ</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <i>— — —</i>	
17. INFORMANT <i>Mrs. W. J. Santman</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage Accident</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>	
(b) DUE TO (c)		2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>22 Aug 1956</i> to <i>5 Oct 1956</i> , that I last saw the deceased alive on <i>5 Oct 1956</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>556 Potomac Street Williamsport Pa.</i> DATE SIGNED <i>10/11/56</i>	
ACTUAL SIGNATURE <i>Paul Hank, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Paul Hank, M.D.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>10-7-56</i>	
22g. NAME OF CEMETERY OR CREMATORIUM <i>Prices Cemetery</i>		22h. LOCATION (City, town, or county) <i>Near Waynesboro Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Scott F. Minnich & Son</i>		24a. ADDRESS <i>Hagerstown Md</i>	
24b. REC'D BY REGISTRAR <i>Oct 11-1956</i>		24c. REGISTRAR'S SIGNATURE <i>E. Lee McElroy</i>	

BUREAU V. 2

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

CERTIFICATE OF DEATH

10745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Washington	MARYLAND	2. USUAL RESIDENCE a. STATE	MD	Where deceased lived If institution, Residence before admission
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		
Rural Smithsburg		50 yrs		Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Margaret	Middle Elizabeth	Last Pryor	4. DATE OF DEATH	Oct. 22.	1956	Day 19	Year
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5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
Female	White	WIDOWED <input type="checkbox"/>	May 6. 1900	36		
		DIVORCED <input type="checkbox"/>				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Wash. Co. Md	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John R. Bowman	Lillie A. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	no	Jennings D. Pryor	Lantz P.O. Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular Accident</i>	
445X	4 days
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	DUE TO
(b) <i>Hypertensive Cardio-Vascular Disease</i>	
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from <i>July</i> , 1941, to <i>Oct. 22.</i> , 1956, that I last saw the deceased alive on <i>Oct. 22.</i> , 1956, and that death occurred at <i>6:15 P.M.</i> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)	DATE SIGNED

ACTUAL SIGNATURE <i>Robert A. Kiefer</i>	M.D.	<i>Blue Ridge Shores, Pa. 22045</i>
PHYSICIAN'S NAME (Type)	Robert A. Kiefer	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 25th. 1956	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Valley Cem.	22d. LOCATION (City, town, or county) Washington Co. MD
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond S. Creager</i>	ADDRESS Thurmont. Md	24a. REC'D BY REGISTRAR DATE OCT 26 '56	24b. REGISTRAR'S SIGNATURE <i>Debra</i>
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BUNNU V S

OCT

1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10726

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Maryland			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION County Capital			d. STREET ADDRESS 503 W. Wilson Blvd		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JEFFERY		First L	Middle E	Last SUNDAY	4. DATE OF DEATH Oct 17 1956
5. SEX - 12	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 5 1896	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months 3 Days 5 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James H. Sunday			14. MOTHER'S MAIDEN NAME Helen B. Riggs		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Circumstances (c) Hemorrhage (Cerebral) 7 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) (State) Washington DC
21. I certify that I attended the deceased from <u>10-8-1956</u> to <u>10-13-1956</u> , that I last saw the deceased alive on <u>10-12-56</u> , 19 <u>56</u> , and that death occurred at <u>Hagerstown</u> M, from the causes and on the date stated above. ACTUAL DATE <u>10-17-56</u> M.D. <u>H. E. D. D.</u> ADDRESS (Street, city, town, state) PHYSICIAN'S NAME (Type) <u>H. E. D. D.</u> DATE STAMPED <u>1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-26-56		22b. DATE THEREOF 10-17-1956		22c. NAME OF CEMETERY OR CREMATORIAL Hagerstown Cemetery	
22d. LOCATION (City, town, or county) Hagerstown		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE H. E. D. D.			ADDRESS 503 W. Wilson Blvd Hagerstown MD		
24a. REC'D BY REGISTRAR Oct 17 1956			24b. REGISTRAR'S SIGNATURE H. E. D. D.		

executed within 24 hours after death. Page 4
completely filled in by the funeral director.
Pages 1 and 2 should be filed with
the papers.

ATTENDING PHYSICIAN: The law requires that an attending physician be retained by the hospital or attending physician.

TO
mc
TO F
po
the
VS A15 (4)
15M 9/55

RECEIVED V. E.

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Wells

10747

10727

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 14 West Wilson Blvd					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 West Wilson Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First LOIS	Middle LEONARD	Last SANNER	4. DATE OF DEATH	Month October	Day 30	Year 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 25 1897	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cedar Rapids Iowa		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Omar S. Leonard				14. MOTHER'S MAIDEN NAME Mary Huff							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev George R. Sanner 14 W. Wilson Blvd Hagerstown Md.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. to lungs, lumbar vertebrae and pelvic bones				8½ yrs							
DUE TO (b) (c)											
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —		(County) —	(State) —		
21. I certify that I attended the deceased from October 30, 1955 , to October 30, 1956 , that I last saw the deceased alive on Oct. 30, 1956 , and that death occurred at 9:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. Robert Wells</i>								ADDRESS (Street, city or town, state) 115 N. Potomac Street		DATE SIGNED 10-31-56	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS		24a. REC'D BY REGISTRAR Oct. 3, 1956		24b. REGISTRAR'S SIGNATURE <i>Robert Powers</i>			

BUREAU V. 2

REGISTRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Lloyd Hoffman
Reg. Dist. No. 302

10748

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY shirton		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY shirton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *** h. County Hospital		d. STREET ADDRESS 17.1 Preston Run		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First C. H.	Middle L.	Last R.	4. DATE OF DEATH Oct. 6, 1956	Month Oct.	Day 19	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1897	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Net		10b. KIND OF BUSINESS OR INDUSTRY Worker		11. BIRTHPLACE (State or foreign country) Copenhagen, Denmark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Harry Schroeder		14. MOTHER'S MAIDEN NAME Elvina Lynne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Schroeder 17.1 Preston Run		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 77 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 1956, to Oct 4, 1956, that I last saw the deceased alive on Oct 4, 1956, and that death occurred at 9:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Lloyd A. Hoffman M.D. 214 N. Pot. St. DATE SIGNED 10/5/56 PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11		22b. DATE THEREOF Oct. 6, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Indore V. Coffey		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 6, 1956		24b. REGISTRAR'S SIGNATURE Charles Powers	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10729 CERTIFICATE OF DEATH

10749

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Washington	
Washington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Rural		2 Days		Washington		Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. DATE OF DEATH		Month		Day		Year	
Washington County Hospital		Washington		October 10		Month		Day		Year	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
Abrian					October	10					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.			
Male		White		12/5/1972		83 yrs.	Months	Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY					
Retired Farmer		Own Farm		Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Christian Shank		Mary Strite									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		Mrs. Samuel Horst		Hagerstown RT#4					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO									
181X		Carcinoma Bladder									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		2 yrs									
(b)											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>9-1-56</u> to <u>10-10-56</u> , that I last saw the deceased alive on <u>10-10-56</u> at <u>19</u> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <u>Edith Dill Jr.</u>		DATE SIGNED <u>10-17-56</u>									
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		10-13-56		St. Paul's Church Cemetery		Washington Co.		Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
W. J. Norment, Hagerstown, Md.				Oct. 13, 1956		Joseph Gossess					

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10750

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - R # 64		c. LENGTH OF STAY IN 16 working		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown, Maryland				d. STREET ADDRESS -									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF (Type or print)		First James	Middle Leroy	Last Shank	4. DATE OF DEATH Oct. 19	Month 19	Day 19	Year 56					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 17, 1933		9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Wk		11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George F. Shank				14. MOTHER'S MAIDEN NAME Annabelle Rohrback									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-28-6309		17. INFORMANT Mrs. James L. Shank - Burkittsville, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)				Crushed Chest - hemorrhage & shock Closed fracture lt. hand									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed beneath a falling grading machine											
20c. TIME OF INJURY Month, Day, Year Hour 7:26 2:45 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural Hagerstown Wash Md		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>S. Robert Welle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-20-56							
EXAMINER'S NAME (Type) S. Robert Welle, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-56		22c. NAME OF CEMETERY OR CREMATORIUM Brethren Cemetery		22d. LOCATION (City, town, or county) Brownsville Wash Md.							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eladille C. Middleton, Md.</i>						24a. REC'D BY REGISTRAR Oct. 23 1956		24b. REGISTRAR'S SIGNATURE <i>Eladille C. Middleton</i>					
VS. A15ME(S) SM 9/55													

• A Few Words

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 by the hospital or attending physician, and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10766 CERTIFICATE OF DEATH

Reg. Dist. No. 10751 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. LENGTH OF STAY IN 7b 2 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) NETTIE		First MIDDLE CATHERINE	4. DATE OF DEATH Oct. 4 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 30, 1875
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (On birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	10c. BIRTHPLACE (State or foreign country) Franklin County, Penna.
13. FATHER'S NAME Albert Carbaugh		14. MOTHER'S MAIDEN NAME Nancy Strong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. H. E. Swope
		311 Bryan Place Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 3</i> , 1956, to <i>Oct. 4</i> , 1956, that I last saw the deceased alive on <i>October 3</i> , 1956, and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Boonesboro</i> DATE SIGNED <i>G.W. LeVan</i>	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Gerald W. LeVan M.D. Boonesboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 6, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE <i>Oct. 10 1956</i>	24b. REGISTRAR'S SIGNATURE <i>John W. Baetz</i>

BUREAU V. 4

1956

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TO HOSPITAL: **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
10730 **Dr E.W. Dotto Jr** **10752**
CERTIFICATE OF DEATH **Reg. Dist. No. 303**

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 906 Maryland Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Mem. Conv. Home				d. STREET ADDRESS		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DAVID		First -----	Middle -----	Last -----	4. DATE OF DEATH Oct 30 1956	Month Oct	Day 30	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4 1874	9. AGE (In years less birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) North Mountain W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel Shaw				14. MOTHER'S MAIDEN NAME Amanda Holmes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles S. Shaw 1715 Preston Rd		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) DUE TO (aa) DUE TO (bb) DUE TO (cc) DUE TO (dd) DUE TO (ee) DUE TO (ff) DUE TO (gg) DUE TO (hh) DUE TO (ii) DUE TO (jj) DUE TO (kk) DUE TO (ll) DUE TO (mm) DUE TO (nn) DUE TO (oo) DUE TO (pp) DUE TO (qq) DUE TO (rr) DUE TO (ss) DUE TO (tt) DUE TO (uu) DUE TO (vv) DUE TO (ww) DUE TO (xx) DUE TO (yy) DUE TO (zz) DUE TO (aa) DUE TO (bb) DUE TO (cc) DUE TO (dd) DUE TO (ee) DUE TO (ff) DUE TO (gg) DUE TO (hh) DUE TO (ii) DUE TO (jj) DUE TO (kk) DUE TO (ll) DUE TO (mm) DUE TO (nn) DUE TO (oo) DUE TO (pp) DUE TO (qq) DUE TO (rr) DUE TO (ss) DUE TO (tt) DUE TO (uu) DUE TO (vv) DUE TO (ww) DUE TO (xx) DUE TO (yy) DUE TO (zz) DUE TO (aa) DUE TO (bb) DUE TO (cc) DUE TO (dd) DUE TO (ee) DUE TO (ff) DUE TO (gg) DUE TO (hh) DUE TO (ii) 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SAVAGE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a bond-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										10753 302
10731 Item 8 railway w-56 et										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 15 min		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 22 West Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF (Type or print) William Henry Shumaker		First	Middle	Last	4. DATE OF DEATH Oct 16	Month	Day	Year	1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 11, 1895	9. AGE (in years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY? W. Va.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Power Plant		11. BIRTHPLACE (State or foreign country) W. Va.						
13. FATHER'S NAME Martin Shumaker		14. MOTHER'S MAIDEN NAME Annie Hutzell								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3995		17. INFORMANT Mrs. Anna May Shumaker Williamsport Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mangled lower abdomen and right hip joint region 911 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO stating the underlying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crane fell on patient								
20c. TIME OF INJURY Hour 12:45 p.m. Oct. 16 '56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory		20f. (City or town) Hagerstown		(County) Wash	(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-17-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-56		22c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery		22d. LOCATION (City, town, or county) Williamsport		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Oct. 20, 1956		24b. REGISTRAR'S SIGNATURE S. Robert Wells				

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b About week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Fenton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Charles	Middle Benjamin	Last Slick	4. DATE OF DEATH Oct. 10 1956	Month Oct.	Day 10	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 15 1887	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 24	12. Hours Hours 12		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Passenger Motor Express Co.		11. BIRTHPLACE (State or foreign country) Leitersburg Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Benjamin Slick		14. MOTHER'S MAIDEN NAME Mollie Zigler		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) To No		16. SOCIAL SECURITY NO. 220-18-0322		17. INFORMANT Mrs. Jack Conley		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon & Rectal Cancer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
						INTERVAL BETWEEN ONSET AND DEATH 10 days			
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20b. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County)	(State)
21. I certify that I attended the deceased from <u>Oct. 10</u> , 19 <u>56</u> , to <u>Oct. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 10</u> , 19 <u>56</u> , and that death occurred at <u>Williamsport</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert L. Leaf</i>		M.D.		ADDRESS (Street, city or town, state) <i>Williamsport, Md.</i>		DATE SIGNED <i>Oct. 16 1956</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12-56		22c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		22d. LOCATION (City, town, or county) Williamsport		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf Williamsport, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Oct. 12 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Shane Powers</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10755	
10733 CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital					d. STREET ADDRESS 401 Pangborn Blvd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE		First	Middle	LAST	4. DATE OF DEATH October	Month	Day	Year			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1893	9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Swartz					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Harry L. Slick		Address Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 44d x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Hypertensive - arteriosclerotic cardiovascular</u> DUE TO <u>disease.</u> ? 18 yrs. (c) <u>Arteriolar nephrosclerosis.</u> ?										INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10. Diabetes Arteriosclerosis Arteriolar nephrosclerosis Uremia Cardiovascular disease										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 10. Diabetes Arteriosclerosis Arteriolar nephrosclerosis Uremia Cardiovascular disease									
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>6/5/44</u> , 19, to <u>10/30/56</u> , 19, that I last saw the deceased alive on <u>10/30/56</u> , 19, and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D. <u>154 West Washington St.</u> DATE SIGNED <u>10:31:56</u>											
22a. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.									
22b. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22c. DATE THEREOF 11/2/1956		22d. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			22e. LOCATION (City, town, or county) Hagerstown, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Louzer Funeral Home R. Franklin Royer		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Nov. 2, 1956		24b. REGISTRAR'S SIGNATURE B. G. Bowers					

GRADUATE

1956

GRADUATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10756

302

Reg. Dist. No.

10734

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b c. STREET ADDRESS Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 401 W. Church St.,		d. STREET ADDRESS 401 W. Church St.,	
3. NAME OF DECEASED (Type or print) Dewey		First Clinton	Last Stanley
4. DATE OF DEATH 10	Month Day Year 1956	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1898
9. AGE (In years last birthday) 58	10. months yrs.	11. BIRTHPLACE (State or foreign country) Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY self employed	
13. FATHER'S NAME Ernest Stanley		14. MOTHER'S MAIDEN NAME Ella Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-0201	17. INFORMANT Mrs. Ella Stanley Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Hagerstown, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH 20 hrs	
DUE TO cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —	(County) —	(State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-11-56
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-12-1956	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill	22d. LOCATION (City, town, or county) Hagerstown
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.		24a. REC'D. BY REGISTRAR Oct 14, 1956	
		24b. REGISTRAR'S SIGNATURE <i>Chas H. Bowes</i>	

YUREAU Y.

OCT 19 1956

DEGEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752

10735

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 16 Life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 300 N. Jonathan Street.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 N. Jonathan Street.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH Stanley	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 4 1903	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 21 Hours 0 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Hagerstown Maryland		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Frank Woodford		14. MOTHER'S MAIDEN NAME Gertrude Matilda							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-4551		17. INFORMANT Charles Perkins 300 N. Jonathan St.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Coronary thrombosis Arterosclerotic CVD.		INTERVAL BETWEEN ONSET AND DEATH minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Maryland		20f. (City or town) Hagerstown		(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from 1/11/56 , 19 19 , to 9/22/56 , 19 19 , that I last saw the deceased alive on 3/22/56 , 19 19 , and that death occurred at 12 PM , from the causes and on the date stated above								ADDRESS (Street, city or town, state) Hagerstown, Maryland	
ACTUAL SIGNATURE Howard N. Weeks, M.D.		M.D. 136 N. Jonathan St., Hagerstown, Maryland						DATE SIGNED 10/22/56	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-1956		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.		ADDRESS 10-24-1956		24a. REC'D BY REGISTRAR Oct. 25, 1956		24b. REGISTRAR'S SIGNATURE John H. Powers			

TO HOSPITAL
may be referred
by the hospital or attending physician.

TO FUNERAL
COTR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1866 or 1870, with a small 1870.

10758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 533 North Locust Street		e. STREET ADDRESS 533 North Locust Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Antonio	Middle (none)	Last Suranno	4. DATE OF DEATH Oct. 29, 1887	Month Oct.	Day 18	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1887	9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Digger		10b. KIND OF BUSINESS OR INDUSTRY Cement Quarry		11. BIRTHPLACE (State or foreign country) Sisuccia, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A. -1944			
13. FATHER'S NAME Michael Suranno			14. MOTHER'S MAIDEN NAME Rose Iorio						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-6877A		17. INFORMANT Mrs. Rose Iazzo, Hagerstown, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Anaplastic Carcinoma of Bladder		INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 31, 1956</u> to <u>Oct 18, 1956</u> , that I last saw the deceased alive on <u>Oct 18, 1956</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Robert L. Campbell M.D. 145 W Washington St Hagerstown Md</u>							
ACTUAL SIGNATURE <u>Robert L. Campbell</u>		DATE SIGNED <u>10/19/56</u>							
PHYSICIAN'S NAME (Type) <u>Robert L. Campbell</u>									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-1956		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Singer Mortuary Funeral Home R. L. Campbell, Owner		ADDRESS Hagerstown, Maryland		24a. REGD BY REGISTRAR Oct. 20, 1956		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>			

BUREAU V. A.

OCT 11 1966

REGISTRED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10759

10737

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 223 Mill St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 223 Mill St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE		First E	Middle THOMAS
4. DATE OF DEATH October	Month 3	Day 1956	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1890
9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Al Miller		14. MOTHER'S MAIDEN NAME Alice Weller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. John H. Thomas		223 Mill St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF UTERUS</u>		INTERVAL BETWEEN ONSET AND DEATH 6 months	
1/4X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-25-</u> , 19 <u>56</u> , to <u>10-3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>October 3, 1956</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>318 N. Potowmack St Hagerstown</u> 10/3/56	
ACTUAL SIGNATURE <u>Paul Harrison</u>		DATE SIGNED <u>10/3/56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL HARRISON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF <u>10/6/56</u>	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR <u>Oct. 5, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

1956 Oct 20

1956 Oct 20

1956 Oct 20

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10760

10757

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) BROWNSVILLE - RURAL		c. LENGTH OF STAY IN 1b 48 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE		d. STREET ADDRESS BROWNSVILLE MD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BROWNSVILLE MD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LENA - MAY - THOMPSON		First	Middle	Last	4. DATE OF DEATH OCTOBER - 27	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY - 20 - 1890	9. AGE (in years last birthday) 66 - 9 - 7 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LEE TOWN, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY ISELIN		14. MOTHER'S MAIDEN NAME ANNIE L. DAVIS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONI		17. INFORMANT EDWARD F. THOMPSON		Address BROWNSVILLE MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/12/2		DUE TO Acute angina		INTERVAL BETWEEN ONSET AND DEATH 30 minu				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension -		DUE TO (c)				20 yrs.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro	20f. (City or town) Boonsboro	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from Sept. 29, 1956 , to Oct. 27, 1956 , that I last saw the deceased alive on Oct. 24, 1956 , and that death occurred at 11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. LeVan		ADDRESS (Street, city or town, state) Boonsboro						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 30, 1956	22c. NAME OF CEMETERY OR CREMATORIUM CHI. OF THE BRETHREN CEMETERY	22d. LOCATION (City, town, or county) BROWNSVILLE MD	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME		ADDRESS Boonsboro MD.	24a. REC'D BY REGISTRAR T. Amerman	24b. REGISTRAR'S SIGNATURE T. Amerman				
			DATE Oct. 31, 1956					

RECEIVED
PURCHASE V. L.

NY 2 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10738

CERTIFICATE OF DEATH

10761

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery	
Washington				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		15-56	
Hagerstown		6 weeks									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		9402 Crosby Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Jackson Convalescent Home											
3. NAME OF DECEASED (Type or print)		First	Middle	Lost		4. DATE OF DEATH	Month	Day	Year		
		JAMES	O.	TOTTON		October	30	19	56		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 19, 1876		80 yrs	3 Months	11 Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Chief Clerk				Washington, D. C. Railroad Terminal		Mechanicsburg, Pa.		U. S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
George B. Totten						Laura Ogilby					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				George Gerbig		Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
77X DUE TO <i>Moderate Cachexia</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cancer Prostate</i>											
INTERVAL BETWEEN ONSET AND DEATH <i>50 days</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>9/14/</u> , 1956, to <u>10/29/</u> , 1956, that I last saw the deceased alive on <u>10/29/</u> , 1956, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
DATE SIGNED											
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u> 10/31/56											
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u> Hagerstown, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/1956		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Grove Cemetery		22d. LOCATION (City, town, or county) Chambersburg, Pennsylvania		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home 1 Franklin Center											
ADDRESS Hagerstown, Md.											
24a. REC'D BY REGISTRAR Nov 3 1956											
24b. REGISTRAR'S SIGNATURE Howard P. Powers											

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU Y. A.

NY 5 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH **BALTIMORE, 18**
10739 **CERTIFICATE OF DEATH**

Dr. B. B. Kneisley

10762

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		COUNTRY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 633 No Mulberry St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Sh. County Hospital				e. DATE OF DEATH Oct 25 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWARD	First	Middle	Last	Month	Day	Year		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug 20 1878	9. AGE (In years less birthday) 78 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker	10b. KIND OF BUSINESS OR INDUSTRY Moller Inc	11. BIRTHPLACE (Not RFD) Hagerstown Md.	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Joseph Trovinger	14. MOTHER'S MAIDEN NAME Susan Eakle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 314-09-3854	17. INFORMANT Mrs. Roena Trovinger	Address 633 No Mulberry St Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 days				
X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral arteriosclerosis				Indefinite				
C (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus; benign prostatic hypertrophy and nephrolithiasis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1945 to Oct. 25, 1956 that I last saw the deceased alive on Oct. 25, 1956 , and that death occurred at 5 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. B. Kneisley</i> ADDRESS 148 West Washington Street DATE SIGNED 10/26/56								
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR Oct. 29, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers		

TO HOSPITAL
may be referred by the hospital or attending physician.
TO FUNERAL
CTO: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death. Page 4

BUREAU V. 1

OCT 21 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

10740

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 29 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL* HAGERSTOWN				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS RT. # 6					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First CHARLES MIDDLE RAYMOND LAST WASTLER		4. DATE OF DEATH OCTOBER		Month Day Year 19 56				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH 8/24/1903		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL MAKER			10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CO.					
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CHARLES BERNARD WASTLER			14. MOTHER'S MAIDEN NAME MARGARET WEBB					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO. 214-09-6877 17. INFORMANT MRS. LILLIE WASTLER					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary artery occlusion</i> DUE TO (c) <i>Diabetes Mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH 5 min					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Nat. white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-6-55, 19, to 10-2-56, 19, that I last saw the deceased alive on 9-6-56, 19, and that death occurred at 5:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Hagerstown, Md		DATE SIGNED 10/4/62
ACTUAL SIGNATURE <i>Stanley Young MD</i>								
PHYSICIAN'S NAME (Type) SEAN L. YOUNG M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/5/56		22c. NAME OF CEMETERY OR CREMATORIUM BROADFORDING CHURCH		22d. LOCATION (City, town, or county) WASHINGTON CO. MD.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment, Hagerstown, Md.</i>			ADDRESS			24a. REC'D BY REGISTRAR Set. 9.1956		24b. REGISTRAR'S SIGNATURE <i>Stan H. Bowers</i>

RECEIVED
BUREAU V
OCT 15 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

10741

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. STREET ADDRESS 13 N. MULBERRY ST.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CATHERINE	Middle IRENE	Last WEITZEL
4. DATE OF DEATH	Month OCTOBER	Day 3	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1904
9. AGE (In years last birthday) 52yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS M. JONES		14. MOTHER'S MAIDEN NAME NORA THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 214-09-5057 17. INFORMANT MR. LUTHER WEITZEL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 3421	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Carcinoma of cervix	
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept., 1957, to Oct., 1957, that I last saw the deceased alive on Oct., 1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldon S. Howland		ADDRESS (Street, city or town, state) 115 W. Wash St Hagerstown MD.	
PHYSICIAN'S NAME (Type) Eldon S. Howland		DATE SIGNED 10/8/1957	
22a. BURIAL, CREMATION, BURIAL <input type="checkbox"/>		22b. DATE THEREOF 10/6/56	
22c. NAME OF CEMETERY OR CREMATORIAL REST HAVEN CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norquist, Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 9, 1957	
		24b. REGISTRAR'S SIGNATURE Robert Rosecrans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10742 **CERTIFICATE OF DEATH**

10766

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 55 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 31 W. Bethel Street.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 W. Bethel Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Charles	Middle Nathan	Last William	4. DATE OF DEATH 10 12 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Celored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar 11 1887	9. AGE (In years lost birthday) 69 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Steam railroad		11. BIRTHPLACE (State or foreign country) Fort Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME Samuel William		14. MOTHER'S MAIDEN NAME Nanme William		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH
						DUE TO arterio sclerotic coronary heart disease 10 yrs		
						DUE TO bronchial asthma 15 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —		(County) — (State) —
21. I certify that I attended the deceased from Oct. 8, 1939 , to Oct. 12, 1956 , that I last saw the deceased alive on Oct. 8, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 10-15-56
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D.						
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1956		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R Watson Jr. Hagerstown Md</i>		ADDRESS <i>Hagerstown Maryland</i>		24a. REC'D BY REGISTRAR Oct. 16, 1956		24b. REGISTRAR'S SIGNATURE <i>Frank Powers</i>		

TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10767
302

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 55 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 1423 Virginia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Matilde Young	First Middle Last	4. DATE OF DEATH Month October Day 15 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1869
9. AGE (In years last birthday) 87 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Thurmont Md.
13. FATHER'S NAME John A. Stull	14. MOTHER'S MAIDEN NAME Anna M. Ramsburg	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	
16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. Lula Itnyer	Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) advanced generalized arteriosclerosis			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) Concussion and shock			
DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and hit head while preparing to retire for the night	
20c. TIME OF INJURY Hour 35 X 9 45 p. m.	Month, Day, Year Oct. 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hagerstown	(County) Wash	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-16-56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-18-56	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son	ADDRESS Hagerstown Md.	24a. REC'D BY REGISTRAR Oct. 20, 1956	24b. REGISTRAR'S SIGNATURE Shall Bowers

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10744

CERTIFICATE OF DEATH

10768

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 Washington Co. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Rex		First Lynn	Middle Young
4. DATE OF DEATH 10		Month 10	Day 20
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-22-1909		9. AGE (In years lost birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY Fairchild	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Newton J. Young		14. MOTHER'S MAIDEN NAME Mary E. Daley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-2483 17. INFORMANT Mrs. Imogene Young Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 545X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 hours Sudden Thrombus block Vessels 12 hours Thrombophlebitis left Femoral Artery (Post-op) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgery 6 days before demise	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, and that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 135 N. Potomac St. Hagerstown, Maryland	
ACTUAL SIGNATURE J. Wilson		DATE SIGNED 10/20/56	
PHYSICIAN'S NAME (Type) burial		22a. BURIAL, CREMATION, REMOVAL (Specify) burial	
22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven	
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct 25, 1956		24b. REGISTRAR'S SIGNATURE K. H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

WISCONSIN STATE PENITENTIARY - MUSKOWE

CERTIFICATE OF DEATH

BUREAU V. 3
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OCT 28 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Dr. Wells 10769 Reg. Dist. No. 303
<p>1. PLACE OF DEATH a. COUNTY Washington MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown</p> <p>c. LENGTH OF STAY IN 1b 48 Hrs</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital</p>					<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Washington</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown</p> <p>d. STREET ADDRESS 301 Mt. Vista Ave</p>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<p>3. NAME OF DECEASED (Type or print) NICOLA</p>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
<p>5. SEX Male</p>		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb 12 1942	9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) In School</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p>			<p>11. BIRTHPLACE (State or foreign country) Hagerstown Md.</p>			<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Nicola Zingarelli Sr</p>					<p>14. MOTHER'S MAIDEN NAME Rose Nease</p>					
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Nicola Zingarelli Sr Hagerstown Md.</p>		<p>Address</p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 919.8 DUE TO Gun shot wound (12 gauge) thru perineal body into abdomen (hemorrhage & shock) Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) stating the underlying cause lost.</p>										INTERVAL BETWEEN ONSET AND DEATH
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun discharged while sitting on a log attempting to light a cigarette</p>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<p>20c. TIME OF INJURY Month, Day, Year Hour 3:06 p.m. Oct. 13 1956</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In woods</p>		<p>20f. (City or town) Rural Boonsboro Wash Md</p>		<p>(County) (State)</p>		
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p>										
<p>ACTUAL SIGNATURE S. Robert Wells</p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>		<p>DATE SIGNED 10-16-56</p>		
<p>EXAMINER'S NAME (Type) S. Robert Wells, M.D.</p>		<p>22b. BURIAL, CREMATION, REMOVAL (Specify) Oct 18 1956 Rose Hill Cemetery</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS</p>		<p>22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.</p>		<p>(State)</p>		
<p>23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.</p>		<p>24b. REC'D BY REGISTRAR Oct. 18, 1956</p>		<p>24b. REGISTRAR'S SIGNATURE</p>						

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BUREAU V. S.

OCT 22 1956

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